Strategic Plan 2006-2011

Mental Health Division

Washington State
Department of Social
& Health Services

Executive Summary

Department of Social and Health Services
Robin Arnold-Williams, Secretary

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- **Operations**
- **Finance**
- **Western State Hospital**
- **Eastern State Hospital**
- **Child Study & Treatment Center**

The Mental Health Division (MHD) operates an integrated public mental health system for people experiencing mental illness who are enrolled in Medicaid and for those who are low income and meet the statutory need definitions. MHD is committed to the belief that it is both necessary and possible to create a seamless system of care that can respond to individual consumers' needs in a cost effective and efficient manner.

The President's New Freedom Commission on Mental Health final report, *Achieving the Promise: Transforming Mental Health Care in America,* published in 2004 concluded that mental illness is a national crisis, largely because the burden of these psychosocial conditions has been heavily underestimated. Washington, like many other states, has yet to transform its mental health care delivery system into a system that addresses the extent of the problem or the complexity of services required to deal with the challenges the state faces. Modeled after the work of the President's New Freedom Commission, the MHD is embarking on a multi-year transformation of the current system that will increase system capability to meet current and future needs of the consumers it serves. The changes are in coordination with other state agencies, the state legislature, and concerned citizen's advisory groups, while envisioning a system that supports recovery, resiliency and the reduction of stigma for consumers. The goal of the transformation is to ensure that consumers in need of mental health services will be able to access appropriate, high quality services designed to support recovery and resiliency in the least restrictive setting no matter where they are in the state. There is a new level of commitment and coordination that will help the MHD capitalize on opportunities to steadily progress toward transformation goals. However, challenges to the realization of the transformation vision remain.

In 1989, the Washington State Legislature enacted the Mental Health Reform Act, which consolidated responsibility and accountability for individuals' community mental health treatment and care through Regional Support Networks (RSNs), also known as Pre-paid Inpatient Health Plans (PIHPs). This consolidation included crisis response and management of the involuntary treatment program. Beginning in October 1993 through 1996, MHD implemented capitated managed care for community outpatient mental health services through a federal Medicaid waiver, creating prepaid health plans operated by the RSNs. In 1996, the waiver was amended to include community inpatient psychiatric care. By 1999, all RSNs were responsible for full risk management of inpatient community mental health care. Legislation passed during the 2005 Legislative Session will re-structure the RSNs so that the MHD may take competitive bids to affect the necessary service outcomes if present providers are not producing the necessary results.

The business of the publicly funded mental health system is to meet the needs of individuals it serves while supporting recovery, resiliency and the reduction of stigma associated with the experience of mental illness. The MHD has built upon regional partnerships to create the best service standard possible from three major models of service:

- Public Mental Health – historically this model has provided care for those who are most at risk and least able to access other sources of services.

- Private sector managed care principles and tools – provide clarity, accountability, utilization management and fiscal alternatives to the continuing challenge of escalating costs in public mental health. Separate

health services operated by Federally Recognized Tribes (Tribes), tribal organizations, and Urban Indian Federally Qualified Health Centers (FQHC) also provide mental health services to people eligible for Medicaid.

The mental health system strives to take the best practices that private managed care has to offer and combine them with the core values of the publicly funded mental health system. This helps ensure that all Washington residents have appropriate and continuous access to the most current and effective treatments, and to the best support services. The system hopes to create a model which is even more responsive to individual consumer needs and preserves natural community supports such as families and advocates. The system will utilize newly formed peer support and family run services. Such a model ensures access to services that meet individual needs, provides community linkages, and integrates with other publicly funded services and natural supports in the most cost effective, responsive manner. Important strides toward improving the system have been made in recent years, but the envisioned system model is not yet in place, and achieving such a model of system coordination and excellence will require numerous changes. This strategic plan is the MHD's initial blueprint for system transformation and will be accomplished through measurable outcomes that demonstrate increased accountability in achieving goals of recovery, resilience and reduction of stigma.

Chapter 1 ● Our Guiding Directions

MISSION

The Mental Health Division (MHD) administers a public mental health system that promotes *recovery*, *resiliency* and *reduces the stigma* associated with the experience of mental illness. The hope is for consumers to achieve recovery and be able to live, work, learn, and participate fully in their communities, including debunking the myth that persons experiencing mental illness are inherently dangerous.

VISION

Transforming mental health care for Washington State residents so that the future holds the promise of life in the community, a job, a home, and meaningful relationships with family and friends.

DEFINITIONS

From the President's New Freedom Commission's Final Report on Mental Health and Washington State Laws:

Adults with a serious mental illness: Persons age 18 and older, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV, that has resulted in emotional impairment which substantially interferes with or limits one of more major life activities.

Consumer: Consumer is a self definition for some persons who have or are currently experiencing mental illness. Consumers bring an important perspective to the mental health system because they have lived the journey of recovery from mental illness and bring the hope of recovery to other people who are experiencing mental illness who can see that recovery is possible and there are many people who have made or are making the journey. Consumer run services are services which promote recovery by supporting individuals on their unique path to recovery. Each individual is supported in their unique path to recovery and therefore drives their own services according to their particular needs. This definition also extends to families of children with a severe emotional disturbance (SED).

Culturally competent services: The delivery of services that are responsive to the cultural concerns of racial, ethnic, and sexual minority groups, including their language, histories, traditions, beliefs, and practices.

Emerging best practice: "Emerging best practice" or "promising practice" is a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.

Evidence-based practice (EBP): The Institute of Medicine definition is the integration of best-researched evidence and clinical expertise with patient values.
In Washington State statute, EBP means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

Serious emotional disturbance: A mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in DSM-IV that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual *up to 18 years of age.*

Stigma: Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma is widespread in the United States and other Western nations. Stigma leads others to avoid living, socializing, working with, renting to, or employing people with mental disorders – especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.

Rebalancing: Adjustments to a state's Medicaid programs and services to achieve a more equitable balance between the proportion of total Medicaid long term support expenditures used for institutional services and the proportion of funds used for community-based support under its State Plan and waiver services. A balanced, long-term support system offers individuals a reasonable array of options, including meaningful community and institutional choices.

Recovery: Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.

Resilience: Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats or other stresses – and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely knit communities and neighborhoods are also resilient, providing supports for their members.

GUIDING PRINCIPLES/CORE VALUES

In early 2005 the MHD embarked on a transformation process and anticipates aligning the goals of the Washington State public mental health system with the goals of the New Freedom Commission final report. Steps to achieving such changes required the division to merge its own internal and external business needs into the Commission's recommendations, producing a document that will guide the transformation for the next five years (the span of this strategic plan). MHD also recognized the need to respond to requests from Federally Recognized Tribes for government-to-government relations directly with the division. In implementing these changes, the division adopted the Commission goals for its own guiding principles:

1. Promote the understanding that mental health is essential to overall health for all Washington residents.

2. Encourage consumers, their families, and advocates to drive their own mental health care and to be involved in their own individual recovery and resiliency process supported by the mental health system.
3. Provide persons with multiple-system needs with an integrated system of care through services that are delivered in community settings whenever possible, and eliminate disparities in mental health services;
4. Establish early mental health screening, assessment, and referral to services as common practice;
5. Utilize data to drive decisions to continuously improve health care services and accelerate research;
6. Require that business practices accommodate a changing environment, to include the use of technology to access mental health care and information.

STATUTORY AUTHORITY

- Chapter 10.77 RCW - Provides for the commitment of persons found incompetent to stand trial or acquitted of a crime by reason of insanity, when found to be a substantial danger to other persons or that there is a likelihood of committing acts jeopardizing public safety or security unless under control by the courts, other persons, or institutions. Also provides an indigent person's right to be examined by court appointed experts.

- Chapter 71.05 RCW - Provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.

- Chapter 71.24 RCW - Establishes community mental health programs through county-based regional support networks that operate systems of care.

- Chapter 71.32 RCW - Establishes that validly executed mental health advance directives are to be respected by agents, guardians, and other surrogate decision makers, health care providers, professional persons, and health care facilities.

- Chapter 71.34 RCW - Establishes mental health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment, and ensures minors' parents/guardians are given an opportunity to participate in treatment decisions.

- Chapter 72.23 RCW - Establishes Eastern and Western psychiatric state hospitals for the admission of voluntary patients.

- Chapter 74.09 RCW - Establishes medical services, including behavioral health care, for recipients of federal Medicaid as well as general assistance and alcohol and drug addiction services.

- Chapter 38.52 RCW - Ensures the administration of state and federal programs for emergency management and disaster relief, including coordinated efforts by state and federal agencies.

Chapter 2 ● The People We Serve

INTRODUCTION TO PROGRAMS

The mental health system exists in a rapidly changing and complex environment. Washington's public mental health system serves consumers in community settings, in state owned and operated hospitals, and in state contracted psychiatric residential treatment facilities for minors. The mental health system is responsible for the care of low income adults and minors, operation of a crisis response system for all of Washington's citizens, administration of the Involuntary Treatment Act (ITA), crisis response in times of disaster, regulation of mental health providers, and development of mental health policy.

PROGRAM DESCRIPTION

Statute dictates that state only money will be used to provide non-Medicaid services.

The program agreements (contracts) for PIHPs and state mental health services give RSNs responsibility for services mandated by state and federal statutes. These services include community support, as well as employment and residential services for persons meeting statutorily defined categories.

Community support services are described in Chapter 71.24 RCW and include the following county community mental health program services administered by the RSNs:

- Outpatient services
- Emergency care services provided 24 hours per day
- Day treatment
- Screening for state hospital admission
- Employment Services
- Consultation and educational services
- Community support services (to include investigation, legal and other non-residential services under 71.05 RCW).

With regard to residential and housing services, the RSNs ensure:

- Active promotion of access to and choice in safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.
- Provision of services to families of eligible people who are homeless or at imminent risk of becoming homeless, as defined in Public Law 100-77, through outreach, engagement, and coordination or linkage of services with shelter and housing.
- The availability of community support services, with an emphasis on supporting consumers in their own home or where they live in the community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in Chapter 71.24 RCW.

RSNs and PIHPs coordinate with rehabilitation and employment services to assure that consumers wanting to work are provided with employment services described in Chapter 71.24 RCW and assist consumers to achieve the goals stated in his/her individualized service plan and provide access to employment opportunities, including:

- A vocational assessment of work history, skills, training, education, and personal career goals;
- Information about how employment will affect income and benefits the consumer is receiving because of their disability;
- Active involvement with consumers served in creating and revising individualized job and career development plans;
- Assistance in locating employment opportunities consistent with the consumer's skills, goals, and interests;
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required; and
- Interaction with the consumer's employer to support stable employment and advise about reasonable accommodation in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Anti-Discrimination Law.

Additionally, RSNs/PIHPs administer the involuntary treatment program and the crisis response system for the citizens of the state of Washington in their service area. In most communities, crisis and involuntary services are highly integrated. The mental health system and the RSN/PIHPs operate the only behavioral health crisis system in the state which, by default, gives them responsibility for conditions not normally considered as mental illness. These crisis services are available to all citizens, regardless of income.

Crisis services include a 24-hour per day crisis line and in-person evaluations to the people of the community presenting mental health crises. Crises are to be resolved in the least restrictive manner and should include family members and significant others as appropriate to the situation and at the request of the consumer. In addition, RSNs/PIHPs ensure access to other necessary services such as medical services and medication, interpretive services, staff with specialty expertise, and access to the involuntary treatment program.

Involuntary treatment services, as part of crisis services, are available in all of the communities of the state 24-hours per day. These services include in-person evaluation of the need for involuntary psychiatric hospitalization. In order to qualify for such an evaluation, the person must be gravely disabled (as defined in 71.05 RCW) and present, as the result of a mental disorder, a likelihood of serious harm (to self, others, or to property). In order to be hospitalized involuntarily, the person must meet the evaluation criteria and have refused or failed to voluntarily accept appropriate evaluation and treatment. While local decisions related to detention are made by community based involuntary treatment staff, state courts are authorized as the only entities that can make the decision to commit individuals under the ITA. Persons needing involuntary care receive it in hospitals, free-standing evaluation and treatment (E&T) facilities, in one of the two state-operated psychiatric hospitals or in one of the Children's Long-term Inpatient Programs (CLIP), or in Residential Treatment Facilities for minors including Child Study and Treatment Center (CSTC).

Under the Federal managed care 1915 (b) Medicaid waiver, RSNs enter into full risk PIHP contracts with the state to provide community inpatient and outpatient services

to Medicaid eligible persons. As prepaid inpatient health plans, the RSN/PIHPs provide community mental health services described in the State Plan to consumers who meet the access to care standards for authorization into public outpatient mental health services. The access to care standards were developed as a response to a term and condition of the 1915 (b) Medicaid waiver renewal which required the state to "develop and implement a standard set of criteria, and a standard set of methods of implementation, to be used statewide in all RSNs/PIHPs for screening, assessment and authorization of services. Criteria and methods for implementation must assure that all Medicaid eligible individuals in need of mental health services have access to needed services. Access to services must be based on clinical criteria and may not be prioritized on the degree of severity or acuity."

The list of State Plan Amendment services include:

- Treatment activities designed to support consumer goals as documented in the consumer's individual recovery plan. These services shall be congruent with the age and cultural framework of the individual and may be conducted with the consumer, his or her family, or others who play a necessary role in assisting the consumer to maintain stability in living, work or educational environments. These services may include, but are not limited to: recognizing and supporting the consumer's individual skills, assisting in the development of independent self care skills; supporting the consumer's recovery through access to health services; counseling and psychotherapy and peer support services. The initial assessment -or intake evaluation- of each individual is critical to developing a supportive recovery plan.

- Counseling and psychotherapy services include:
    - Brief intervention
    - Family treatment
    - Group treatment services
    - High intensity treatment
    - Individual treatment services (to include case management)
    - Medication monitoring
    - Mental health services provided in residential settings
    - Rehabilitation case management
    - Special population consultation
    - Psychological assessment

- If the consumer is in crisis, both crisis services and stabilization services are available for all consumers, regardless of Medicaid eligibility.

- If requested, medication management is available: Prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services.

- High Intensity Treatment teams, and evaluation and treatment centers (E&Ts) are available to maintain consumers in their communities and provide hospital diversion services.

- Respite care for caregivers, clubhouses, and supported employment are also services that are available to promote recovery and resiliency for consumers and their families.

- Peer Support services are newly approved services which support the Recovery model. Self-identified consumers are trained and certified to provide this service under the consultation, facilitation, or supervision of a mental health professional who understands rehabilitation and recovery.

- Day treatment (day support) for individuals needing an intensive rehabilitative program which provides a range of life skills training to promote improved functioning or a restoration to a previous higher level of functioning.

Each PIHP is funded according to the number of Medicaid eligible persons living within their catchment area. The funding mechanism does not necessarily mirror demand for mental health services, since community mental health service demand tends to be stable as Medicaid caseloads vary. A strong economy does not decrease the need for mental health services and a slower economy may not indicate a large increase in the need for services.

The RSNs/PIHPs authorize and pay for community inpatient psychiatric care for residents in their service areas. As Medicare and private insurance continue to cut costs by trimming services and rates, community hospitals are examining their operations in order to eliminate or curtail services that are not cost effective. The result is that community hospitals are downsizing or threatening to close psychiatric wards, and the public mental health system is forced to deal with unmet demand. This situation is compounded by the fact that mental health costs grow at a rate higher than the state expenditure limit, similar to other health care costs. The threatened lack of community inpatient capacity and perceived funding shortfalls have caused RSNs/PIHPs to think about alternative ways to serve patients appropriately, while maintaining cost effectiveness and quality.

As in all of health care, community based, outpatient services are generally the first and most desirable set of services for dealing with health conditions. When acute situations arise or when outpatient services do not succeed, inpatient hospital care has been relied upon. The transformation of the mental health system will require enhancing community options so that life in the community may be maintained even in crisis.

The MHD owns and operates two adult psychiatric hospitals and one psychiatric hospital for children which are subsidized by the county PIHP. Overall, these hospitals provide care for approximately 1,300 adults and 47 children each day. The MHD also holds contracts for the operation of three children's long-term inpatient (CLIP) programs. These facilities provide capacity for an additional 44 children statewide. The state continues to grapple with higher demands for patient care from the courts, the legislature, Centers for Medicaid & Medicare Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Within the adult hospitals, there are two systems of care: civil and forensic (legal). Patients can enter the civil wards of the hospital through involuntary civil commitment. Voluntary admissions are not common due to lack of available space. There are processes whereby a patient may be civilly committed upon being discharged from the criminal justice system, or patients may be civilly committed without entering the criminal justice system. Some persons are committed into the forensic units after behavior in the civil units is viewed as criminal. State hospital civil capacity is an integral part of the community's resource for treating persons with

mental illness. As such, the RSNs are responsible for maintaining their use of state hospital capacity within contractual limits. The state is moving toward placing further responsibility for state hospital capacity with the RSNs. If a community sends more persons to a state hospital than their allowable quota per capita, they may face liquidated damages to pay for the additional hospital costs.

Patients enter forensic wards through the criminal justice system. Services provided are generally evaluations, restoration of competency to stand trial, and care of those found not guilty by reason of insanity. State hospital forensic census is controlled by criminal law changes and court action. The most significant impacts on forensic services have come about as a result of recent legislation affecting offenders with mental illness. These laws have generally increased the number of persons served by the forensic units at the hospitals and have resulted in some services being performed at community jails. The transformed mental health system aims to create triage units and additional mental health courts wherein persons with mental illness, when possible, will be diverted from the criminal justice penal system. In this manner, they will be assessed for treatment at the onset of involvement with the state in an attempt to intervene and prevent incarceration.

In addition to overseeing RSN services, the MHD also works directly with Tribes in a department-level tribal mental health workgroup to improve government-to-government relations. The Tribes are significant MHD partners as some Washington tribes provide extensive health care services, including outpatient mental health services, alternatives to inpatient care, and specialty mental health services such as wrap-around. However, Tribes do not have inpatient mental health care facilities and rely on the RSNs to provide access to inpatient services.

MHD is also involved in emergency management planning work with the Federal Emergency Management Administration (FEMA) and plays a role in planning for a statewide comprehensive response. DSHS plays a support role to the Department of Health, the lead agency on this effort. Specific tasks assigned to the mental health system include:

- Assist in assessing the mental health needs of the population;
- Provide mental health training materials for system emergency preparedness;
- Assist in arranging training for mental health outreach worker;
- Assess the adequacy of application for federal crisis counseling grant funds;
- Address worker stress issues and needs through a variety of mechanisms;
- Maintain a current roster of available staff that can be utilized to assist in major crisis.

Chapter 3 ● Environmental Context

APPRAISAL OF EXTERNAL ENVIRONMENT

Demographic and Economic Trends

The latest forecast of the state population predicts general population growth rates of 1.1 percent each year. Increases in the number of persons in selected age groups will place new demands on social services within Washington State. An aging state population and the lack of consistent access to advanced medical technologies have resulted in a growing number of persons living with and requiring assistance for chronic illness, cognitive impairments, and functional disabilities. Racial and ethnic diversity is increasing, most recently with an influx of people from Northern Africa and the former Soviet Union who are Medicaid-eligible and are likely to need services. There is also a significant population of Mexican nationals who need services but who are not necessarily eligible for Medicaid.

The uncertainty of the state's current economic climate threatens the viability of social service programs that help many needy families, children and vulnerable adults. To achieve budget reductions, DSHS has recently closed field offices and reduced its workforce. It is clear that DSHS will no longer be able to provide the level and scope of services and supports that it has in the past. Tough decisions are being made to prioritize and restructure business functions across DSHS.

Economic recession has resulted in the loss of health insurance along with jobs. The combination of tax cuts, economic downturn, and military investments has left very limited amounts for increasingly costly health care expenses.

Rapid growth in Medicaid enrollment has been matched in recent years by substantial rises in Medicaid costs. While the federal government covers about half of these total costs, the state's share has been rising as much as a half billion dollars a biennium, with the most dramatic increases felt in the state's pharmaceutical costs. Today the cost of funding our medical assistance program from all sources represents a full 14 percent of the state budget. Across all state agencies, medical costs alone account for 45 percent of the growth in the last biennium**.**

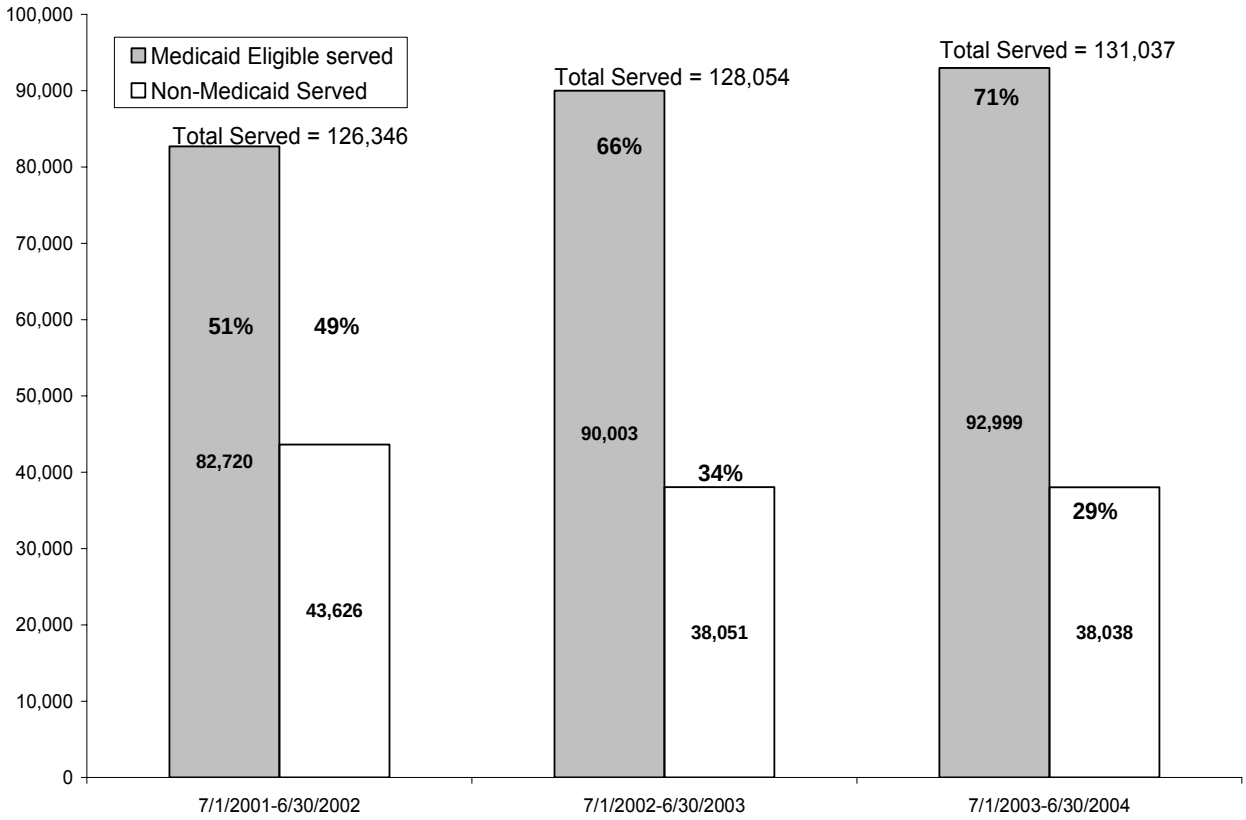
An additional burden to the system this past year which will continue to put pressure on the system is the interpretation by CMS that savings generated by the RSNs operating managed care programs cannot be used by the program but must be placed in a Community Reinvestment Fund. This is a significant change from CMS policy dating from the beginning of managed care (1993). RSNs are no longer allowed to use their savings to purchase non-Medicaid services for Medicaid eligible individuals, or to use them to fund some non-Medicaid persons. Savings placed in the Community Reinvestment Fund must be used only for Medicaid eligible persons and services must be approved by CMS in advance.

TRENDS IN CUSTOMER CHARACTERISTICS

Mental health consumers include Medicaid eligible persons, publicly funded persons not eligible for Medicaid, and all citizens of the state (for crisis, ITA and disaster response services). Tribal mental health consumers receiving tribal services or care in tribal clinics are not reflected in MHD service data unless they are enrolled in an RSN. The percentage of tribal consumers who receive both tribal and RSN services is presently unknown.

Chart 1 shows the Medicaid population accessing mental health services over the last three biennia has increased dramatically as the number of non-Medicaid consumers has fallen off. In FY 2004, 131,037 people –approximately 93,000 of whom were covered by Medicaid - utilized mental health services in community outpatient settings.

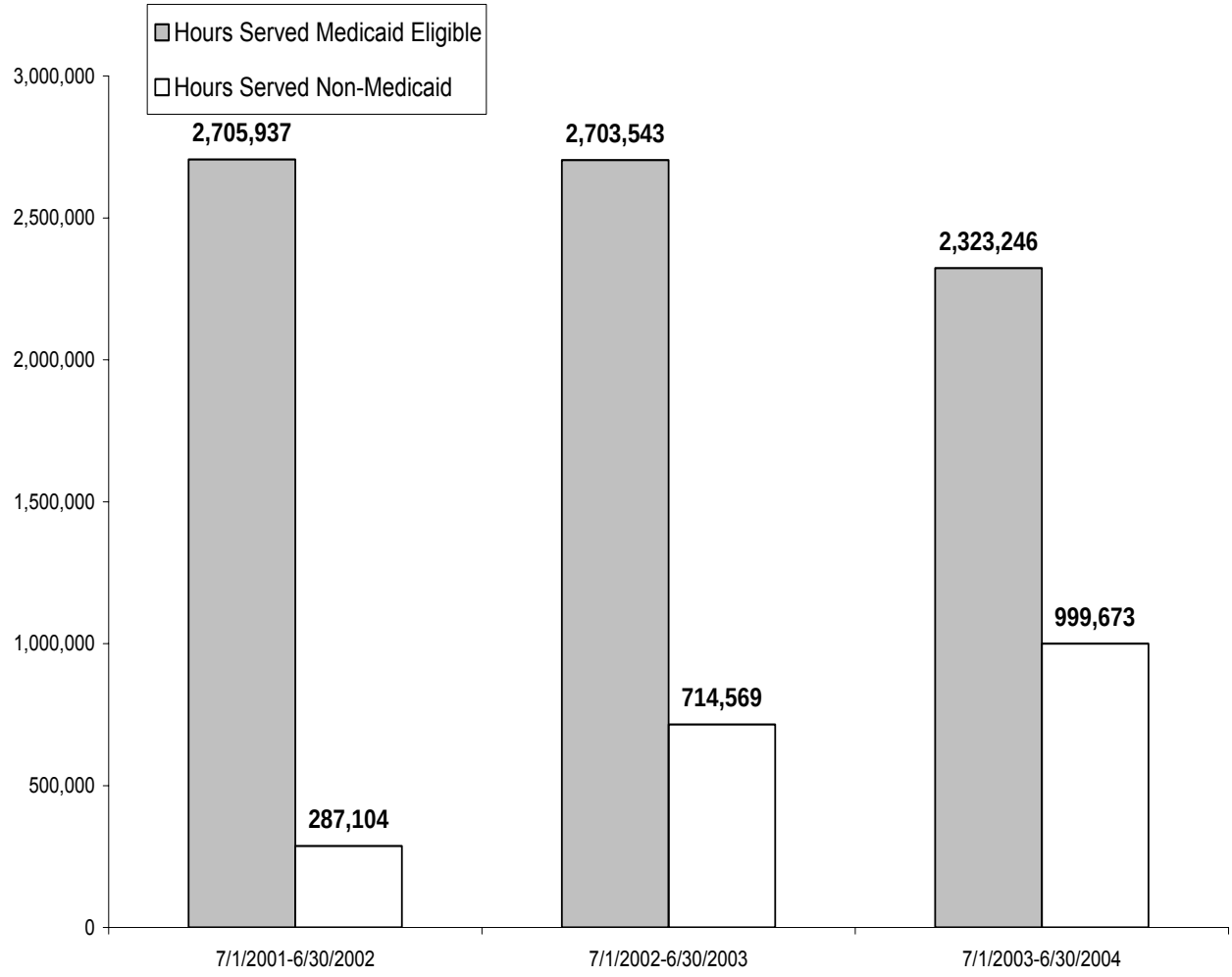
Chart 1 - Medicaid/Non-Medicaid Services



From: Washington State Department of Social and Health Services State-Wide Publicly Funded Mental Health Performance Indicators Fiscal Year 2004 (August 2005)

Chart 2 shows Medicaid eligible people received over 80 percent of service hours delivered in Fiscal Years 2003 and 2004. Some consumers receive non-acute services. These tend to be minimal hours as would be consistent with a mental health evaluation. Non-Medicaid eligible persons received less than 20 percent of the service hours delivered. The non-Medicaid eligible persons being seen by the RSNs are mostly crisis and, on average, receive less than 15 hours of service per year.

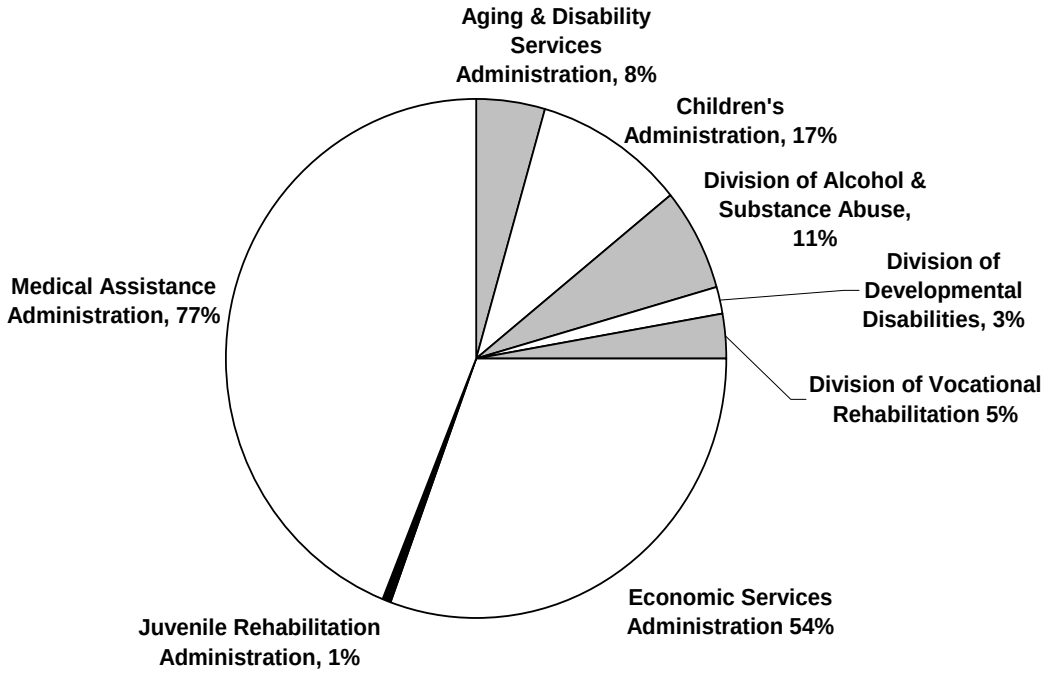
Chart 2 - Services Hours



From: Washington State Department of Social and Health Services State-Wide Publicly Funded Mental Health Performance Indicators Fiscal Year 2004 (August 2005)

Many mental health consumers tend to be customers of other human service programs as well as of mental health (see Chart #3). Many children utilizing mental health services are consumers of the Medical Assistance Administration, Children's Administration, and/or Juvenile Rehabilitation Administration. Many adults accessing services are also involved with substance abuse, aging or the criminal justice system. Additionally, many patients at the state hospitals are elderly or developmentally disabled. There is an increased need to collaborate among service systems to ensure appropriate treatment of each consumer.

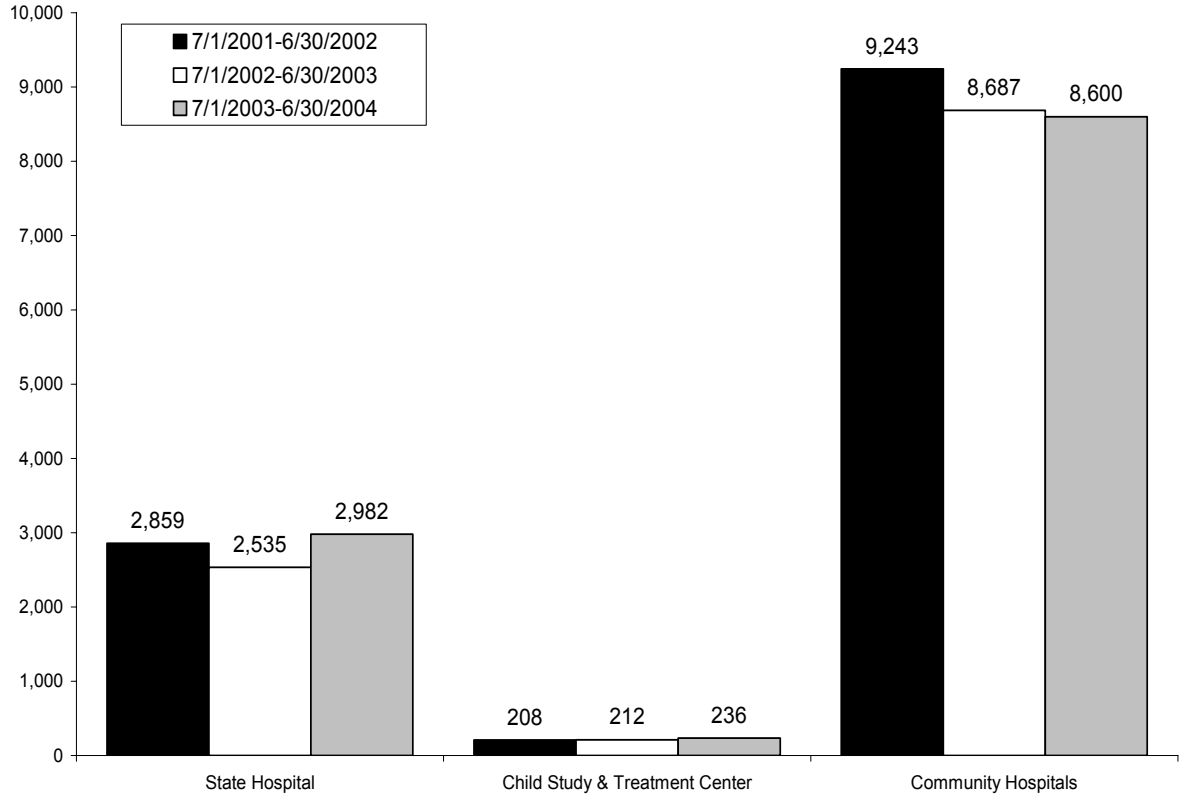
Chart 3 – Percentage of Mental Health Consumers Receiving Services from Other DSHS Programs (FY2003)



From: DSHS–RDA Client Services Database (CSDB) for FY2003

Specific groups of mental health consumers are requiring more specialized treatment geared toward ensuring their recovery. Recent court decisions have placed emphasis on treating people in the most appropriate setting, rather than placing persons in state hospitals for lack of a more appropriate placement. This most clearly affects developmentally disabled consumers and others who are no longer benefiting from state hospital inpatient level of care.

Chart 4 - Individuals Receiving Inpatient Services



From: Washington State Department of Social and Health Services State-Wide Publicly Funded Mental Health Performance Indicators Fiscal Year 2004 (August 2005). Children's Long Term Inpatient Program (CLIP) data

Mental Health Service Disparity Between and Among Racial and Ethnic Groups

Mental health service penetration and utilization rates often differ greatly between and among racial and ethnic groups. Over the past three years (FY02 through FY04), penetration rates for community outpatient services have been twice as high for African Americans and Native Americans[1] (in FY04, 4.6 percent and 4.2 percent respectively) than for Asian/Pacific Islanders (0.7 percent), Caucasians (1.9 percent), and Hispanics (2.0 percent). Penetration rates for community inpatient care for African Americans and Native Americans[2] remain significantly higher across all three years (3.4 percent and 2.3 percent respectively for FY04) than for Asian/Pacific Islanders (0.5 percent), Caucasians (1.2 percent) and Hispanics (0.7 percent). Over all three years, community inpatient utilization rates (average number of bed days) are also significantly greater for African Americans (56.8 in FY04) and Native Americans (32.7) than that of Asian/Pacific Islanders (11.1), Caucasians (18.3), and Hispanics (10.6). The trend differences are magnified further in State Hospital data, with penetration rate trends significantly higher for African Americans and Native Americans across the three-year span. State hospital utilization data was even more dramatic. In FY04 the average bed days for African Americans and Native Americans (151.4 and 85.2 days, respectively) far exceeded that of Asian/Pacific Islanders (24.8 average bed days), Caucasians (57.2), and Hispanics (29.5). In response to these trends, MHD's statewide Performance Data Group chartered a work group to examine available penetration and utilization data to determine possible reasons for these disparities.

Coordinated Services for Children

Between nine percent and 13 percent of children (age 9-17)[3] have serious emotional disturbances that affect their functioning in family, school or community activities. An additional number of children have been identified by the school system as having a serious behavioral disability. These children are served not only by the mental health system and the school system but often times by the Children's Administration, Juvenile Rehabilitation Administration, Medical Assistance, Division of Alcohol and Substance Abuse, and/or Department of Health.

RSNs are funded to provide community-based care to children and youth who receive public mental health benefits. Crisis and ITA services are the same as those described above for adults. The range of services the RSNs offer includes:

- Individual, family, or group therapy
- Prescribing and monitoring medications
- Education on the disorder, reducing stress, resources, problem-solving, and other subjects of interest to families
- Support groups and advocacy for families
- Case management to help coordinate services
- Referral to other organizations in the community

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[1] *Washington State Department of Social and Health Services State-Wide Publicly Funded Mental Health Performance Indicators Fiscal Year 2004 (August 2005).*

[2] *Ibid.*

[3] *The Future of Children, Summer/Fall 1998*

Additionally, RSNs/PIHPs are implementing protocols for service delivery for the provision of services to children and youth who receive services through cross-system initiatives. These protocols were designed with the assistance of care providers, parents and other concerned citizens. RSNs/PIHPs have been involved in the design of the services in order to respond to the Select Committee's report to Secretary Braddock for hard-to-place adolescents. Most recently, they have been involved with the DSHS Children's Mental Health Workgroup, an improvement initiative sponsored by the Assistant Secretaries of the Health and Recovery Services Administration, Children's Administration and Juvenile Rehabilitation Administration.

Acute inpatient services are provided either in community psychiatric hospitals or in special units set aside for children and youths. One of the system challenges is maintaining the ability to treat children near where they live. For example, a child from Lewis County may have to be admitted to Fairfax Hospital in Kirkland rather than in a facility close to their home. In contrast, an adult from Lewis County might have access to St. John's in Longview or Southwest Hospital in Vancouver.

The CLIP facilities provide inpatient care for those children and youth who need extended inpatient services. Standing agreements between CLIP and the RSN detail the responsibility for the resource management of these 91 beds. Local capacity remains a problem for CLIP resources as well.

The strengths of the children's system are:

- Committed staff at all levels of the system
- Parent organizations and advocacy
- MHD's strong leadership with regards to support of parents has led to increased awareness of the issues they face with regards to obtaining and maintaining appropriate care for their children
- Statewide Action for Family Empowerment of Washington (SAFE-WA), a statewide parent council brings a united voice to the MHD
- Wraparound process which involves natural supports and focus on normalizing activities for children and youth
- Local cross-system collaborative teams
- Hospital diversion
- Juvenile justice diversion
- School-based care
- Early Periodic Screening, Diagnosis, & Treatment (EPSDT)
- Growing youth advocacy
- Growing use of promising evidence-based interventions

Challenges to the children's system include:

- Children's needs are often overshadowed by the needs of adult consumers
- Lack of a comprehensive needs assessment
- Inadequate funding for children and youth services
- The service system becomes the child's community rather than integration within the community (e.g., when a child needs a tutor, the "system" will provide the tutor as part of the service package rather than work with the school to assign a tutor)
- Differences between public and private insurance benefits
- Voluntary relinquishing of custody by parents to get services for their child
- Lack of early intervention and prevention funding for publicly funded children.
- Negative attention (media or other) paid to a few children or youth drives a system response

- Local community short-term inpatient capacity
- Insufficient collaboration mandates from other systems
- Shortage of specialty trained clinicians, including child psychiatrists.

The growing formal network of parents and others is attracting attention from allied systems of the mental health structure, resulting in an increasing number of conversations in other programs about the utilization of parents, neighbors and friends as care resources. The mental health system has received requests for technical assistance on the best way to incorporate family and friends into the planning process to deal with children with serious emotional or behavioral needs. Although this network has become more accepted by providers as their community involvement expands, they are not yet universally seen as a resource. This group continues to have a strong belief in their role as a system partner and will continue to be involved as coordination continues to grow. One way this coordination occurs is through the former Parent Council, supported by the MHD. The Parent Council was renamed SAFE-WA (Statewide Action for Family Empowerment of Washington) and became the recipient of a federal Substance Abuse and Mental Health Services Administration grant to be the statewide parent/family network, and a major partner in the larger children's system grant submission. SAFE-WA has representation from all of the recognized parent advocacy and support groups and meets quarterly to bring a united voice to the division's management.

ACTIVITY LINKS TO MAJOR PARTNERS

The MHD is actively working to strengthen relationships with all partners in the mental health system and in the community to validate or implement the concept of recovery, resiliency and stigma reduction. Efforts shall include outreach to employers in the private sector and more collaboration with the Division of Vocational Rehabilitation. Major partners include tribes, Urban Indian Federally Qualified Health Plans (FQHC), RSNs, consumers, families, community mental health providers, state hospital patients, labor unions and allied systems. Allied systems include formal systems such as the Children's Administration, Juvenile Rehabilitation Administration, Aging and Adult Services Administration, Division of Alcohol and Substance Abuse, Division of Developmental Disabilities, Office of Superintendent of Public Instruction, and Department of Corrections to name a few. However, within the mental health system, other community resource programs such as churches, food banks, homeless shelters and the YMCA and YWCA are often utilized. The mental health system also relies on the use of support systems such as friends and neighbors. Consumers and their families are represented on several MHD advisory groups and provide direction and feedback regarding the mental health system. The MHD's Office of Consumer Affairs supports a Consumer Roundtable Network which provides direct input to the division and Outreach for Recovery and Consumer Advocacy (ORCA), a statewide consumer and self-advocacy training program which conducts conferences and events all over the state.

The Washington State Mental Health Planning Advisory Council (MHPAC) is a group mandated by Washington and Federal Law. The council reviews, monitors and evaluates the division's policies, plans and budgets making recommendations to assure a strong link between government decisions and consumer, family and

advocates needs and concerns. MHPAC's subcommittees include groups dedicated to the needs and concerns of children, elders, ethnic minorities, and sexual minorities.

Fifty-one percent of MHPAC's membership reflects the strong voice of consumers, family members and advocates. Other MHPAC members represent RSNs, service providers, and state agencies. MHPAC's new goals are adopted from the six goals found in the New Freedom Commission's final report, *Achieving the Promise: Transforming Mental Health Care in America*. These goals are reflected in the MHD's Strategic Plan as:

1. Washington State residents understand that mental health is essential to overall health;
2. Mental health care is consumer and family driven;
3. Disparities in mental health services are eliminated;
4. Establish early mental health screening, assessment, and referral to services as a common practice;
5. Excellent mental health care is delivered and research is accelerated;
6. Technology is used to access mental health care and information.

The division's Office of Consumer Affairs (OCA) has received approval to conduct a two-year, statewide consumer and self-advocacy training program. Initiated in 2004, ORCA is meant to meet the requirements of Executive Order 03-01 to improve the division's service delivery to consumer customers, assisting and supporting consumers statewide. Over the course of the program, OCA staff will:

- Use surveys and focus groups to identify areas requiring improvement;
- Assist consumers in finding services and resolving problems;
- Utilize provider agency consumer advisory groups for consultation and program involvement;

In addition, the OCA is responsible to:

- Educate consumers and collect consumer voice.
- Extend reach and message of state voice.
- Include federal and regional partners in listening to views on consumer issues of interest.
- Provide public speaking and education on mental health and anti-stigma awareness. Promote values of DSHS and HRSA/MH recovery advancements.
- Process and present consumer, client and family voice. Search for success experience and recommendations
- Retain focus that OCA's over-arching mission is to assist leadership to know and value consumer insight in order to help move the system to more recovery treatment options.
- As part of Director's Office and member of Senior Management Team, provide leadership with system evaluation and feedback; planning input; and policy and design development.

MHD staff meet regularly with RSN administrators and assures there is representation from the RSNs on any committee formed to change, establish, or set policy. These committees also include providers, consumers, parents and family advocates and, at times, allied system partners. Topics for discussion range from performance indicators to Washington Administrative Code (WAC) changes.

MHD meets with the Washington Community Mental Health Council (WCMHC), a group representing some community mental health centers that provide services under subcontract with the RSNs. The MHD also seeks and receives input from community mental health centers that do not belong to the council but who subcontract with the RSNs.

As part of quality management processes, there have been four MHD sponsored System Improvement Groups (SIG) that met for specific tasks. The SIG is a group of stakeholders representing consumers, parents, family advocates, community mental health centers (both council and non-council members), Washington Institute for Mental Illness Research and Training (WIMIRT), RSNs and MHD. Membership is divided between the eastern and western sides of the state and has no duplicative service area representation. SIG recommendations have been incorporated into the division's quality management plan and into planning, policy, and contracting activities.

Other system improvement groups were formed as part of the implementation of the Balanced Budget Act (BBA) and the requirements for quality improvement oversight. The most prominent quality improvement group is the Implementation and Design Group (IDG). This group uses the foundation established by previous SIGs, taking and refining recommendations from the division's Quality Council and developing statewide quality improvement initiatives. Like previous SIGs, the IDG membership is a mix of MHD staff, customers, and stakeholders committed to positive system change. Most recently IDG members conducted a thorough review of the mental health access to care standards, making numerous recommendations to the MHD Quality Council. IDG has also developed a proposal form and process for statewide quality improvement initiatives, launching the initiative at the 2005 Behavioral Health Conference in Yakima.

In addition to the Quality Council and the IDG, three other quality management groups bring providers, RSNs and other stakeholders together to assist the MHD in managing the statewide mental health system. The Performance Indicator (PI) Group has produced the "State-Wide Publicly Funded Mental Health Performance Indicators" Report annually since FY 2000. The Performance Data Group (PDG) merged with the PI Group in mid-2005 and has expanded the system data reviewed and packaged it for decision-making by the Quality Council.

The Quality Steering Committee (QSC), made up of the quality improvement managers from MHD headquarters and the three state hospitals, meets regularly to discuss and resolve issues of mutual interest and concern such as employee satisfaction and facility performance reporting. QSC members are also members of IDG and PDG, and on occasion represent their CEOs at the quarterly Quality Council meetings. Such membership crossover is encouraged, and has helped keep the committees aligned with each other.

MHD and the Division of Alcohol and Substance Abuse staff the Co-Occurring Disorders Interagency Committee (CODIAC), a committee of providers from mental health, chemical dependency, other cross-systems and consumers. This group has been in existence for approximately 12 years and addresses co-occurring mental illness and substance related disorders. The two divisions often engage in joint studies and are currently developing a joint demonstration project serving persons with co-occurring disorders in Yakima.

The Inpatient Roundtable, a technical assistance group comprised of staff from MHD, the Health and Recovery Services Administration, (formerly the Medical Assistance Administration), RSNs, and community hospitals, meets on a routine basis to consider community psychiatric hospital resource management issues.

MHD continues to recognize that many consumers served by other DSHS programs have mental illness and that these individuals should also be served by the mental health system. To ensure that these individuals have their full needs addressed, the division continues to pursue a strategy that strengthens collaboration and service delivery between systems and programs.

One such shared strategy is meeting the ongoing challenge to determine by survey or assessment how to structure children's mental health services to best meet the needs of children and their families. In December 2003, the Assistant Secretaries for Children's Administration (CA), the former Health and Rehabilitative Services Administration (which housed the MHD) now the Health and Recovery Services Administration, and the Juvenile Rehabilitation Administration (JRA) convened a work group to address the mental health needs of children and youth who are served by these three systems within DSHS. The DSHS Children's Mental Health Workgroup published a report in July 2004 that included nine recommendations. Two significant themes which received attention both within the Workgroup and from stakeholders were the dynamic tension between statewide consistency and local discretion, and a perceived gulf between family-driven, culturally appropriate services and EBPs.

The Washington Medicaid Integration Partnership (WMIP) is a collaborative effort of the Health and Recovery Services Administration (formerly the Medical Assistance Administration-MAA), Division of Alcohol and Substance Abuse (DASA), MHD, and Aging and Disabilities Services Administration (ADSA). The mission of the Partnership is to design and implement a new consumer-focused, coordinated Medicaid delivery system that improves health status and treatment outcomes while reducing expenditures for senior and disabled Medical Assistance consumers. WMIP will serve adults (age 21+) who are categorically eligible for services paid for by DSHS as aged, blind, or disabled Medical Assistance consumers. This is a voluntary participation pilot for up to 6,000 senior and disabled consumers living in Snohomish County (part of North Sound RSN). The pilot was implemented in January 2005 and mental health services came on-line in October 2005. The project has a sophisticated evaluation component that will measure outcomes based on comparisons of change in outcomes for consumers participating in WMIP relative to consumers who received services through current delivery systems.

Another shared strategy is the constellation of activities funded by the Medicaid Infrastructure Grant (MIG). This grant has a focus on consumer recovery, and has included the following actions which will now be accounted for in annual reports to the public and to the MHPAC for review and evaluations:

- Numerous trainings statewide on Healthcare for Workers with Disabilities and Ticket to Work
- Seven "Pathways to Employment" conferences held throughout the state which provide information on employment-related programs, housing, transportation, social security benefits and other information related to recovery

- Employment track offered at the annual Behavioral Health Conference held each June
- Twenty conference scholarships awarded to consumers involved with employment-related programs
- Ongoing collaboration with other DSHS partners in order to increase the infrastructure of employment-related supports for persons with disabilities
- Membership on the advisory board for the Center for Continuing Education on Rehabilitation
- Continued funding expected for an FTE in 2005
- Continued funding is expected to initiate an Enhanced Peer Support Training module, offered in addition to the 40 hour required training for certification.

Crisis services are a critical aspect of the service package available to all Washington citizens. The Cross-System Crisis Initiative (CSCI) was formed to implement the recommendations from the Cross-System Crisis Response Project, a joint collaboration and partnership between DSHS and the Association of County Human Services (ACHS). The purpose of the project was to bring together a diverse group of stakeholders to study the current crisis system and make recommendations for an improved, integrated cross-system crisis response capability. The public mental health system serves as the default crisis response and involuntary commitment system for people with a wide range of emotional and behavioral issues, including serious mental illness, developmental disabilities, organic mental disorders (such as dementia and traumatic brain injury), and mental illness combined with drug and alcohol dependence (co-occurring disorders). The CSCI is seeking to create efficiencies for crisis responders, to develop targeted diversion and short-term detention options, and to develop appropriate resources to keep individuals from utilizing costly state hospital beds whenever feasible.

STAKEHOLDERS INPUT

Throughout the duration of this plan, MHD will meet with the following stakeholder groups for ongoing input and comment on the division's strategic plan:

- Regional Support Networks (April/June)
- Washington Community Mental Health Council (April/May)
- Mental Health Planning and Advisory Council (through December)
- Indian Policy Advisory Council (July)
- Hospital Executive Committee meetings (ongoing)
- National Alliance for the Mentally Ill-NAMI (TBD)
- Consumer Roundtable (TBD)
- Parent groups (April – June)
- Consumer group (June)
- Union (via State Hospital input)
- Other DSHS programs – DASA, DDD, Medical Assistance/HRSA (quarterly)
- Traumatic Brain Injury Advisory Board

These groups will be contacted on a regular basis for input on any amendments to the plan. The plan will also be posted on the division's website (http://www1.dshs.wa.gov/Mentalhealth/) to provide opportunities for public comment.

FUTURE CHALLENGES AND OPPORTUNITIES

Overall funding within the MHD has not kept pace with health care inflation in recent years. Funding increases due to rising Medicaid caseloads have been offset by reductions implemented for a variety of reasons. This funding picture has created a general sense that the mental health system in Washington State is under-funded, and some RSNs have expressed concerns about whether or not they can continue to operate the mental health system in their service area. In addition, any new requirements implemented by federal or state authorities are vigorously opposed by RSNs, unless funding is provided to implement and sustain them.

The community mental health system is funded under a capitation arrangement, with county-based RSNs receiving monthly payments intended to cover the cost of providing mental health services in their service areas. Funding provided is not identified to specific consumers, nor is it specified for certain services or programs. RSNs are directed to accomplish all requirements in the contract with the overall funding they receive. As part of a recent actuarial study, the MHD has made great strides in its ability to identify where and how funds are being spent, and whether funding is sufficient to accomplish the goals set forth in statute, rule and contract. Expectations from other programs requiring services for persons with mental illness in their caseload are actually increasing. Each program is asking the mental health system to increase services to persons identified with mental or behavioral disorders. Funding provided to RSNs not specifically identified as spent on mental health direct services is at risk of being cut from the budget.

In the state hospitals, similar issues exist. State hospitals are funded at a level tied to "funded capacity" or census. The adult hospitals risk over-expenditure if patients are admitted beyond the funded capacity, even though patients admitted under criminal statutes cannot be turned away. State hospitals also encounter resistance from the community if they attempt to refuse civil admissions: a policy instituted since the February 2001 earthquake. State hospitals overall are able to keep expenditures within allotted limits as long as census remains relatively within funded levels, but the ability to collect revenue from Medicare, Medicaid and private insurance for patients in the hospital is tenuous. A great deal of emphasis has been placed on revenue collection in the past couple of years, increasing overall collections. These efforts have also shown the need for clear supporting documentation for revenue and the need for an integrated revenue collection and accounts receivable system.

To deal with these issues, the MHD is conducting studies to examine need within the community system and is continuing to identify enhancements at the state hospitals that will increase revenue collection. The focus of one study is on the need for inpatient capacity for persons with mental illness and the appropriate capacity of state hospitals. An actuarial study has been conducted to identify the overall funding needs of community managed care programs. The division continues to ensure that state hospital billings are compliant with federal rules for reimbursement. Financial reporting requirements from the RSNs will need to be enhanced to ensure that funds spent and allocated on certain consumer groups are appropriately reported to the legislature and to other stakeholders.

As a result of participation in the Sixteen-State Pilot Indicator Project and the 2001 Joint Legislative Audit and Review Committee (JLARC) report, the MHD has moved toward a performance and outcome-based system rather than one that emphasizes

process. To prepare for this change, the division, RSNs, and providers spent considerable time updating and revising data reporting requirements and guidelines. The BBA of 1997 has also placed a heavy emphasis on the use of data for management and quality improvement activities.

MHD has also begun the march toward implementation of EBPs. The MHD received a National Institute of Mental Health (NIMH) planning grant in 2003 and was able to create both internal and external work groups to look at issues related to the implementation of evidence-based practices. A subcommittee of MHPAC has been tasked with development of a work plan to guide further efforts. The work plan includes:

- Disseminating the practices and training providers on their use;
- Identifying barriers to implementation statewide (e.g., funding, licensing, monitoring, and oversight);
- Creating a process for reviewing and selecting new EBPs and promising practices;
- Hosting a conference highlighting the Committee's work.

As part of this Council's activities, they have created an internal work group to coordinate EBP efforts across the MHD (Assertive Community Treatment-ACT, Dialectical Behavioral Therapy-DBT, and family psycho-education), DASA (integrated COD services), Child Welfare (wraparound and therapeutic foster care services), Juvenile Justice, and the former Medical Assistance Administration, now Health and Recovery Services Administration (medication algorithms).

IMPACT OF NEW STATE LEGISLATION

The MHD is also presented with several key opportunities as the result of activities over the past year and accomplishments during the 2005 regular Legislative Session. The potential impacts upon RSNs, division headquarters, and institutional facilities are yet to be fully realized, but some of the challenges also present opportunities that will affect the implementation of the strategic plan.

As a result of activities stemming from the Joint Legislative and Executive Task Force on Mental Health Services and Financing, issues of mental health were elevated to unprecedented levels of scrutiny and awareness statewide. Capitalizing on this momentum is an opportunity for the MHD to drive even more significant changes for improving the public mental health system.

Changing the way Mental Health Services are Delivered

Implementation of E2SHB 1290: Restructuring of the RSNs and New Procurement Processes

Engrossed Second Substitute House Bill (E2SHB) 1290 changes the way in which community mental health services will be delivered, and is intended to advance the state mental health division's ability to be a prudent purchaser of mental health services.

With the passage of E2SHB 1290, the legislature wanted to strengthen the public mental health system so that people experiencing mental illness receive treatment and support services focused on resilience and recovery and ideally within their own communities. The bill intends that adults and children with mental illness, their

families, and their advocates are intimately involved in designing mental health services that reduce unnecessary hospitalization and incarceration. The legislation is a move toward a statewide system that supports consumers to be able to live, work, learn, and participate fully in their communities. E2SHB 1290 aims for consumers to have the community and personal qualities that empower them to rebound from trauma, adversity, tragedy or other stresses and can lead productive lives.

E2SHB 1290 promotes public policy that focuses on mental health treatments and services that are evidence and research-based (meaning they are programs or practices that have demonstrated results in clinical trials or have some research demonstrating effectiveness but do not yet meet the standards of evidence-based practices, or EBPs.) The legislation also aims to ensure public mental health services are delivered efficiently, effectively, and consistently across the state. Coordination of services within the department is emphasized and includes partners outside of DSHS such as the Office of Superintendent for Public Instruction, state mental hospitals, county authorities, community mental health providers, and other support services. Such coordination will also, to the maximum extent possible, include families and advocates of persons with mental illness.

Procurement of Mental Health Services

E2SHB 1290 requires the Department to initiate a process for procurement of mental health services. This process began in July 2005 and is being led by a team comprised of Mental Health Division and Medical Assistance Administration staff with support from Mercer Human Resource Consulting. The process is unfolding in two phases: Phase 1 allows all existing regional support networks (RSNs) to qualify to administer local mental health services through a "Request for Qualifications" (RFQ) process. Phase 2 occurs in the event an existing RSN for a certain area does not qualify during the RFQ process. This phase will include a request for proposals (RFP) process to identify an entity to serve as the RSN in that region. The bill expands the definition of an RSN to include entities other than county authorities such as tribal authorities and private managed care organizations. During Phase 2, any responses to the RFP from interested private sector or tribal authority bidders will be considered.

Integrated Behavioral Health Treatment

Implementation of E2SSB 5763: Omnibus Substance Abuse and Mental Disorder Treatment Act

Engrossed Second Substitute Senate Bill (E2SSB) 5763 is legislation intended to integrate treatment of co-occurring mental and substance disorders to achieve successful outcomes and recovery through a series of changes to previous mental health and substance abuse treatment policies and practices.

DSHS is required to select and contract for two pilot sites (one urban and one rural) to test changes to the chemical dependency involuntary treatment law. The pilots will integrate mental health and chemical dependency crisis response, and allow for 72-hour detention and 14 day commitment into a secure detoxification facility.

The Department invited all counties in the state to submit proposals for the Integrated Crisis Response Pilots and received five proposal responses. Two successful bidders were chosen: Pierce County and the counties that make up the North Sound RSN. MHD and DASA are working together to develop contracts for the

services and a training curriculum for the designated crisis responders. The two pilots will be operational as of March 1, 2006.

The Department is required to develop an integrated and comprehensive screening and assessment process for chemical dependency and mental disorders and co-occurring chemical dependency and mental disorders.

A cross-agency team that includes MHD, DASA, DOC, and WIMIRT has begun implementation work. RSNs & mental health providers were invited to provide input into the selection of a screening tool. Screening tool recommendations have been established, and will be presented to interested stakeholders in August. An assessment process team is being assembled and will join the cross agency team to develop the assessment process. An invitation to this team will be sent soon. RSN administrators are on the invitation list.

On September 12 – 13 2005, a workshop to provide information and gather stakeholder input regarding the screening and assessment process took place at the Co-Occurring Disorder conference in Wenatchee. Ongoing and statewide training is being planned for 2006.

Other New Initiatives

Implementation of SHB 1154: Mental Health Parity
For the past several legislative sessions, mental health advocates pressed diligently for the passage of legislation that would require private insurers to cover mental health services comparably to their coverage of other medical and surgical services. During the 2005 regular legislative session, the state's first ever mental health parity act was passed and signed into law by Governor Gregoire.

The law applies to commercial health plans regulated by the Washington State Insurance Commissioner and offered by an employer of more than fifty employees. All state employee health plans offered by the Public Employees Benefits Board and Washington State Basic Health are also included. While some plans are not covered, the fact remains that 2005 was a landmark year for legislation related to mental health issues, and the four-year phase in of the parity legislation is likely to benefit many citizens of Washington affected by mental illness.

Washington's Transformation Grant Proposal
Washington Governor Gregoire is leading *Partnerships for Recovery: Transformation the Mental Health System in Washington State* with the full support and participation of the director of every department, agency, and division serving people with mental illness in the state of Washington. With consumers and family members as equal partners, Partnerships for Recovery has launched a deep transformation effort to achieve the goals of the President's New Freedom Commission for all people in the State of Washington.

All aspects of the transformation will rely on the participation of consumers and families, including their membership in Transformation Work Group, in outreach, education and training, policy formation, evaluation and public education campaigns. This will ensure that the transformation process will give birth to a comprehensive, culturally competent, fully integrated, consumer and family centered system committed to continuous improvement.

The template for Partnerships for Recovery is the President's New Freedom Commission Final Report. However what will emerge in Washington State will be unique to the needs of the consumers and families of Washington. Partnerships for Recovery is building the infrastructure to an on-going process of planning, action, learning and innovation that will result in measurable improvements in the lives of both young and old throughout the State.

Key elements of the initiative will include:

1. A social marketing initiative to reduce the stigma of mental illness, increase awareness of mental health as an essential part of health, and promote support for mentally ill individuals in the community and workplace.
2. Strengthening of the statewide infrastructure for consumer and family support and advocacy
3. Development of a comprehensive approach to insure participation of consumers as service providers.
4. Reduction of ethnic and geographic disparities and enhancement of the cultural competence of all systems.
5. Adoption of a strengths-based, consumer-driven care planning model in all state departments serving mentally ill individuals.
6. Implementing training and fiscal and regulatory incentives for the expanded use of evidence-based recovery focused practices.
7. Development of a web-based data infrastructure that will support direct service, planning, and evaluation and form a basis for system-wide accountability to citizens and consumers.

The restructuring of HRSA and Mercer Government Human Services Consulting expanded review of HRSA/MHD

In February 2005, the MHD contracted Mercer Government Human Services Consulting (Mercer) to conduct a review of the division's operations and make recommendations for changes. The final Mercer report (released in May 2005) detailed suggestions for MHD's organizational structure, maximizing resources and efficiency, and assessed the division's procurement and oversight of the Medicaid managed care program.

In June 2005, DSHS Secretary Arnold-Williams commissioned Mercer to conduct a comprehensive review of the new Health and Recovery Services Administration's Medical Assistance and DASA operations. The final recommendations of the second Mercer assessment were complete in October 2005.

INDIAN POLICY PLAN

MHD acknowledges the need for consultation with tribes in developing and finalizing the MHD Strategic Plan, including the Indian Policy Plan. To date, this consultation has not been initiated by MHD. This is an example of an activity the MHD will prioritize in its renewed commitment to comply with DSHS Policy 7.01 and increase government-to-government relations with tribes. The strategic planning process must proceed sooner than time would permit for consultation. MHD anticipates consultation will occur and may result in amendments or revisions to this Strategic Plan. This will be completed by January 2006.

The MHD is committed to compliance with DSHS Administrative Policy 7.01. The policy directs each administration of DSHS to work in consultation with the Federally Recognized Tribes (Tribes) and the Recognized American Indian Organizations (RAIO) to develop a biennial Policy 7.01 Implementation Plan and Annual Progress Reports that are regionally and headquarters specific. In the MHD, the regional Implementation Plans and Annual Progress Reports will be submitted by the RSNs and will be specific to the RSN's catchment area.

The MHD has committed to exploring and expanding the opportunities for operating in a government-to-government manner with the Tribes. The MHD has previously expressed this commitment through:

- Sponsoring the first ever Washington *Tribal Mental Health Summit* in November 2003;
- Signing a Memorandum of Agreement with the Nisqually Tribe in February 2005 which recognizes full faith and credit for a tribal court order to initiate forensic evaluation and treatment by WSH staff, combines the use of the tribal court and the tribal mental health treatment staff with use of the state's forensic staff at WSH, provides the Nisqually Tribe access to forensic mental health evaluations for Native Americans criminally charged in the Nisqually Tribal Court, extends the opportunity for community-based forensic evaluations and inpatient treatment to the Nisqually Tribes-services currently available to state courts;
- Actively participating in department level Tribal Workgroups;
- Meeting with individual tribes, when requested, to work on 7.01 Plans;
- Provision of annual Federal Block Grant mini-grants to Tribes and Recognized American Indian Organizations for culturally appropriate mental health activities;
- Provision of technical assistance to RSNs on compliance with DSHS Administrative Policy 7.01; and
- Planning and initial implementation of 7.01 training for MHD, RSN, and mental health provider staff.

The MHD recognizes some tribes have expressed an increased interest in exercising their sovereignty in areas of mental health care, as evidenced by request for recognition of Tribally Designated Mental Health Professionals, and requests for recognition of Tribal Court Orders for involuntary treatment.

The MHD, working with Tribes, will continue to explore and develop methods to facilitate increased government-to-government relations. This exploration continues the work of the 2003 Tribal Mental Health Summit. Currently, the MHD is investigating the use of a Tribal/Children's Long Term Inpatient Program Administration Memorandum of Agreement to facilitate direct authority by Tribes to refer youth to CLIP facilities.

The MHD will increase consultation activities with Federally Recognized Tribes in keeping with it's commitment to respond to tribal requests for government-to-government relations, and implementation of the Centennial Accord.

Chapter 4 ● Transformation Goals, Objectives, Strategies and Performance Measures

MHD has set six transformation goals for 2006-2011:

1. Promote the understanding that mental health is essential for overall health for all Washington residents, irrespective of age, race/ethnicity, or culture.
2. Encourage consumers and families to drive the mental health care system, and be involved in program planning and their own recovery and resiliency process;
3. Provide persons with multiple-system needs with an integrated system of care through services that are delivered in community settings whenever possible, and eliminate disparities in mental health services;
4. Establish early mental health screening, assessment, and referral to services as common practice;
5. Utilize data to drive decisions to continuously improve health care services and accelerate research;
6. Require that business practices accommodate a changing environment, to include the use of technology to access mental health care and information.

A. IMPROVE CONSUMER HEALTH AND SAFETY – PUBLIC VALUE

Goal 1:
Promote the understanding that mental health is essential for overall health for all Washington residents.

Objective #1:

Actively promote recovery, resiliency and the reduction of stigma for persons experiencing mental illness across the life span.

Strategies:

- MHD will outreach and showcase consumers' skills and abilities as a means of stigma reduction.
- MHD will provide opportunities to allow consumers to share their stories of recovery with others.
    - Develop advertisement campaigns promoting recovery and community support of persons in recovery from mental illness; consumers involved in the design and implementation of campaign.
    - Work with counties and agencies to promote recovery, resilience and the reduction of stigma through the mental health system.
    - Create a recovery manual in collaboration with the Washington Institute (similar to the domestic violence manual) and distribute it throughout the system, including the Criminal Justice System.
    - Develop triage units and create additional mental health courts wherein persons with mental illness, when possible, will be diverted from the criminal justice penal system and will be assessed for

treatment at the onset of involvement with the state to intervene and prevent incarceration.

Objective #2:

Require that all persons experiencing mental health issues be treated with the minimum standard of care equivalent to respect, understanding and compassion.

Strategies:

- Develop mission statements for persons working with the MHD and contract agents that incorporate the values of respect, understanding and compassion as fundamental in treatment of persons experiencing mental illness.
- Work with counties and agencies to promote these values.
- Adopt philosophies such as the Rochester New York Emotionally Disturbed Persons Response Team which makes every effort to preserve the dignity of every individual encountered who is emotionally disturbed or experiencing mental illness.
- Provide training for clinical providers to adhere to these minimum standards of treatment of respect, understanding and compassion.

Measures:

A. Increase the number of brochures, informational fact sheets, and trainings delivered by the MHD that provide information on recovery and resiliency.
B. Identify the number of people who receive mental health services as a diversion from the criminal justice system (e.g. diversion programs, mental health courts). Increase the number of consumers diverted from the criminal justice system.
C. Increase the number of consumers showing positive outcomes in the areas of: employment, independent living, social connectedness, substance use.
D. Increase the number of consumers who report increased levels of self-esteem, hope, and illness self-management.
E. Increase the percentage of consumers reporting they are treated with respect, dignity and compassion by their treatment providers.

B. IMPROVE CONSUMER SELF-SUFFICIENCY – PUBLIC VALUE

Goal 2:
Mental health care is consumer and caregiver driven, with consumers, families, caregivers and advocates involved in individual recovery and resiliency process.

Objective #1:

Consumers and family members direct their own recovery and resilience planning.

Strategies:

- Implement a resilience and/or recovery model whereby the consumer and their community of family or caregivers lead determining items needed for their individual recovery and resilience plan.
- Develop an education and training program to assist care providers (to include primary care physicians) and consumers in understanding resilience and recovery to ensure consistent use of these words and meanings.
- Expand the information on SSDI, SSI, Ticket to Work, Medicaid buy-in, and other employment opportunities for adult consumers.
- Require the integral involvement of consumers in the development of their recovery and resilience process/plans.
- Increase programming and recreational activities for state hospital patients across the life span at all times to help patients maintain social, physical, and psychological well being.
- For long term patients, introduce skill building and work tasks to foster responsibility and self-esteem.
- Request revisions for Chapter 71.24, 71.34 and 71.05 RCW to reflect current program realities and to clearly state the rights of consumers.
- Provide training to consumers in the development of Wellness Recovery Action Planning (WRAP). Training will be offered to consumers at least annually.
- Expand information on and promote accessibility to Social Security Administration, Medicare and other community services that promote/support older adults in maintaining optimum function and meaningful activities.
- Expand peer counseling to support consumers across the life span.
- Develop and implement concepts and programs that prioritize goals and outcomes that foster autonomy rather than maintenance and co-dependency.

Objective #2:

Involve consumers, their families, caregivers, and advocates in all program design and planning of the recovery and resiliency process.

Strategies:

- Increase the role of consumers across the life span and families in quality management activities within MHD, state hospitals, RSNs, Community Mental Health Centers (CMHC), and CLIP via the MHPAC.

- Continue to support the Consumer Roundtable**.**
- Showcase examples of consumer/caregiver involvement across the lifespan that demonstrate recovery, resiliency and reduction of stigma.
- Insist on consumer/caregiver presence across the life span on state hospital governing bodies and encourage presence on private hospitals governing boards, particularly where Medicaid money is utilized.
- Provide training to assist consumers and caregivers to find their own voices and tell their own stories.
- Implement a culturally competent service delivery plan.
- Provide mentoring to consumers and families prior to their membership on client/consumer committees and their attendance at stakeholder meetings.

Objective #3:

Communicate with consumers, and ensure the sustainability of the active involvement of consumers and their advocate caregivers across the life span.

Strategies:

- Utilize the approved consumer self-advocacy training & Executive Order project
- Promote consumer and caregiver advocacy to assist with legislative proposals and as a tool to influence legislation that promotes recovery and resiliency
- Develop and train consumers as mental health system advocates in order to expand committee membership expertise
- Publish and make available Mental Health Statistics Improvement Project (MHSIP) survey reports in an easily understood manner
- Develop, publish, and mail informational benefit brochure annually to consumers. Identify in the document a way to communicate with the MHD directly to allow for feedback and comment
- MHD staff meets directly with consumers and caregivers through focus groups and/or attendance at meetings
- MHD supports and receives information from clubhouses to help programs to connect and share a common goal
- The Office of Consumer Affairs (OCA) will develop an addition to the MHD's web page that is specific to adult consumers containing frequently asked questions, definitions, resources, guides, etc. Clubhouses and consumer-run programs will be added as a resource to the MHD's web page.
- Provide training to consumers in the use of MHD web site

Objective #4:

Respond to funding and infrastructure changes in the mental health system to sustain the goal of consumer driven services.

Strategies:

- Develop an independent Ombudsman program to support consumer driven services
- Work with the Joint Legislative and Executive Task Force on Mental Health Services and Financing to implement system change
- Develop and implement a plan to monitor and evaluate the impact of system changes on consumer care at the provider level
- Create workgroups to explore the programmatic and financial impact of changing the system structure.
- Examine current law and rule to determine by survey or assessment revisions needed to change the system structure.
- Conduct a risk management review of the system structure change.
- Study the current continuum of care to identify community alternatives to residential, crisis and inpatient capacity needs.

Measures:

A. Increase the number of consumers who report that they are informed of their right to have a mental health advance
B. Increase the percentage of consumers reporting that providers respected their culture.
C. Increase the percentage of consumers reporting they are treated with respect, dignity and compassion by their treatment providers.
D. Increase the percentage of treatment plans that include either peer support or clubhouse activities
E. Increase the percentage of consumers who are aware of their rights and the grievance process
F. Increase the percentage of consumers and caregivers who reported that they directed their treatment plan.

C. IMPROVE ACCESSIBILITY AND SERVICE INTEGRATION – CUSTOMER PERSPECTIVE

Goal 3:
Persons with multiple-system needs receive integrated care, services are delivered in community settings wherever possible, and disparities in mental health services are eliminated.

Objective #1:

Increase coordination of agencies with consumers with multiple treatment needs.

Strategies:

- For consumers across all age spans, require through contract that service protocols be implemented and followed with Children's Administration, Juvenile Rehabilitation Administration and Aging and Disability Services Administration.
- Develop a service protocol for consumers across all age spans to provide them with one integrated plan of care.
- Assure comparable access to services, and monitor the results of services for effectiveness.
- Review and address barriers identified through the development of service protocols and through RSN reports to the MHD on the progress of service protocol development within their service area.

Objective #2:

Develop and improve formalized delivery agreements with other DSHS administrations and allied departments.

Strategies:

- Develop Memoranda of Understanding or working agreements to share with the field including requirements, confidentiality, documentation, filing, and budgeting.
- Make staff aware of intra-agency and inter-agency agreements and ensure periodic review.
- Increase and improve discharge planning from inpatient settings for multi-system consumers.
- Community Mental Health Agencies and RSNs participate in A-Teams and Families and Children Together projects.
- Expand cross-system care coordination efforts within DSHS including ADSA, DVR, Medical Assistance, DASA, DDD and with OSPI, DOC and other relevant agencies.
- Require integrated treatment plans that focus on skill building, autonomy and decreased dependency on the publicly funded mental health system.

Objective #3:

Develop and promote responsive crisis interventions that are recovery oriented with psychiatric hospitalization utilized only as a last resort.

Strategies:

- Develop recovery oriented crisis interventions plans
- Implement recovery oriented crisis intervention plans
- Evaluate the effectiveness of DMHP protocols

Objective #4:

There is a continuum of care and improved access for both outpatient and inpatient services with the appropriate level of service provided to the consumer in the community as a priority.

Strategies:

- Support parity initiatives for mental health care to reinforce its importance in overall health for consumers across the life spectrum and cultural groups.
- Support legislative initiatives for mental health that promote recovery and resiliency and reduction of stigma.
- Reduce the use of adult state psychiatric hospitals, the children's state psychiatric hospital (Child Study and Treatment Center), and Children's Long Term Inpatient Programs (CLIP) by increasing community care modalities that provide comparable wrap around care.
- Provide consumers across the life spectrum who are being discharged from the state hospitals with extensive community reintegration and resiliency supports to ensure the successful integration into the community and to decrease the likelihood of hospital readmission.
- Provide youth discharging from the state hospitals, CSTC, and CLIP facilities and their families/care providers with extensive community reintegration and resiliency supports to decrease the likelihood of hospital readmission.
- Conduct a needs assessment of inpatient and diversion capacity (for all age groups) at the local level. Develop a plan to make needed resources available.
- Develop appropriate capacity for a flexible, integrated continuum of inpatient service, available regionally and statewide.
- Provide clearer definition of level of care for the entire continuum based on an underlying principle of treating persons experiencing mental illness with dignity and respect.
- Make quality mental health care very accessible and geared to recovery and resiliency.
- Continue to review Access to Care Standards for non-Medicaid consumers with expanded capacity for skill utilization and building and promoting autonomy in order to foster less dependency upon the publicly funded system of care.
- Develop a cultural appropriateness plan to insure that all mental health services are provided in an acceptable manner
- Develop continued care criteria for the state hospitals which include an awareness of the community life of the consumer and support the continuation of life in the community.
- Develop clear discharge criteria for the state hospitals which require written "acceptance of transfer of responsibility" by community providers thereby ensuring timely continuity of care.

Objective #5:

There is a statewide utilization review process that includes a standard level of care for continuing stay and discharge criteria for outpatient mental health services.

Strategies:

Using the division's quality management infrastructure to:

- Review data for continuing care and discharge issue trends
- Develop statewide continuing care and discharge criteria.

Measures:

A. Increase the number of consumers showing positive outcomes in the areas of: employment, independent living, social connectedness, substance use.
B. Increase the number of consumers who report increased levels of self-esteem, hope, and illness self-management.
C. Increase the use of EBPs for consumers across the life spectrum.
D. Reduce the use of restraint and seclusion at ESH, WSH, and CSTC
E. Reduce the use of restraint and seclusion in CLIP facilities
F. Increase the percentage of consumers with COD diagnoses who receive COD treatment.
G. Increase the number of adults with serious mental illness who receive supported employment services.
H. Increase the number of adult consumers who report they have timely access to mental health services.
I. Increase the percentage of consumers who are seen in the mental health system within seven days following discharge from inpatient services
J. Increase the number of community diversion and crisis beds available across the state.
K. Increase the number of CMHAs using one or more of the 16 currently identified EBPs.

D. IMPROVE PREVENTION AND CARE – INTERNAL PROCESS

Goal 4:
Early mental health screening, assessment, and referral to services are common practices for consumers across life spectrums, ethnicity and culture.

Objective #1:

Promote the mental health of all citizens across life spectrums and ethnicity and cultures.

Strategies:

- Promote screening and early intervention in primary health care facilities and schools (e.g. EPSDT) thereby actively promoting the expectation of comparable decreases in instances of mental health crisis later in life.
- Collaborate with other state agencies serving children and their families to provide screening for children and youth in potentially high-risk settings such as child welfare and juvenile justice settings.
- Build on service coordination and collaboration developed as part of the Children's Mental Health Initiative (Children's Administration, Juvenile Rehabilitation Administration, and Mental Health Division).
- Provide training for primary health providers to screen for and recognize early signs of emotional and behavioral problems, and to offer connections to appropriate interventions.

- Provide information, support and treatment for parents who are experiencing mental health problems to allow them to better address the needs of their children.

Objective #2:

Improve and expand school mental health programs.

Strategies:

- Collaborate with other state agencies serving children and their families to address the mental health needs of children and youth in the education system.
- Develop a continuum of care to provide services and supports for children and youth in schools that includes training, prevention, early identification, early intervention, and treatment.
- Provide consistent State-level leadership and collaboration between education, general health, and mental health.

Objective #3:

Screen for co-occurring mental and substance abuse disorders and link with integrated treatment.

Strategies:

- Collaborate with other state agencies serving children and youth to screen for co-occurring mental health and substance abuse disorders in the juvenile justice system.
- Collaborate with other state agencies serving children and youth to screen for co-occurring mental health and substance abuse disorders in the child welfare system (such as children in foster care).
- Identify and initiate coverage for core components of evidence based collaborative care, to include a comprehensive range of treatment modalities, i.e. clubhouses, peer counseling, respite care, and supported employment.
- Involve consumers and their caregiver advocates in program design and advocacy.
- Investigate the use of blended and braided funding to provide integrated programming.

Objective #4:

Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Strategies:

- Identify and consider coverage for core components of evidence-based collaborative care, to include case management and disease management.

- Provide consultation to primary care providers by mental health specialists that do not involve face-to-face contact with consumers.
- Provide expanded Gatekeeper programming as an outreach to older or isolated individuals who may benefit from behavioral health screening.
- Expand mental health services in all residential and community care settings.
- Implement a comprehensive screening process to promote early intervention and treatment for people with mental disorders, including dementia.

Measures:

A. Evaluate the percentage of WMIP enrollees who are screened for behavioral health treatment , set baseline and targets
B. Increase the number of children and adolescents reporting improved school attendance.
C. Increase the number of older adults receiving mental health services.

E. IMPROVE QUALITY ASSURANCE AND SUSTAINABILITY—INTERNAL PROCESS

Goal 5:
Improve data analysis in order to continuously improve mental health care services and accelerate research.

Objective #1:

Implement evidence-based care statewide and develop a common approach for the provision of mental health services for consumers across the life spectrum using evidence-based practices.

Strategies:

- Work with MHPAC on evidence-based practices (EBPs) and promising practices to identify needs and barriers to EBP implementation. Develop clear funding streams and start up costs associated with each EBP.
- Develop requests for legislation to solicit on-going funding for EBPs not covered by Medicaid.
- Provide training and technical assistance and follow-up to sites implementing currently defined EBPs.
- Develop policies and monitoring strategies for EBPs (to include fidelity assessments, incentives, increased monitoring of consumer outcomes, and a process for incorporation of new EBPs).
- Develop reporting guidelines for EBPs.
- Showcase MH agencies with effective EBPs.
- Collaborate with other DSHS agencies to implement cross-system EBPs.

- Provide training, technical assistance for evaluation, and follow-up of new promising and innovative practices.
- Continue review of clinical practices, with inclusion of promising practices as they become supported by evaluation and consumer outcomes.
- Meet with SAFE-WA to dialogue and receive input with regard to the best approaches for including families and youth in the provision of services
- Meet with Health Action to dialogue and receive input with regard to the best approaches for including youth in the provision and development of services to youth
- Support the increased involvement of youth in system development
- Track the progress of joint strategies developed with other administrations and divisions.

Objective #2:

Increase dissemination and use of information throughout the mental health system.

Strategies:

- Increase access to information for all program, planning, fiscal and management personnel.
- Increase information dissemination throughout MHD headquarters with multiple short reports, decrease process and time-span for approval of reports.
- Create web-based, user-friendly report generating system that can provide standard reports or real-time queries of the MHD data.
- Train MHD staff on new report generating system, make available to all headquarter staff.

Objective #3:

Develop an information system that integrates quantitative and qualitative data across the mental health system and facilitates access to reports.

Strategies:

- Build on existing information systems to incorporate and integrate computerized data from Quality Assurance and Improvement (QA&I) reviews.
- Build on existing information systems to incorporate and integrate other qualitative data (e.g. OCA, QA&I, Ombudsmen, and P&P).
- Better integrate information systems throughout DSHS to better identify older adults service needs for the development of more specific outcome measures.

Objective #4:

Use performance indicator reporting to manage and improve the mental health system through contracts and quality improvement efforts.

Strategies:

- Develop Performance Indicators from the consumer outcome system.
- Develop Performance Indicators that are specific to older adult issues.
- Develop consensus within MHD about goals/benchmarks for these performance indicators.

1. Maintain involvement in national performance indicator efforts through CMHS, NASMHPD, ACMHA, NCQA, and JCAHO.

- Develop positive incentive system for RSNs following JLARC recommendations.
    1. Develop system to recognize programs/providers/RSNs that exceed expectations or demonstrate best practices.

Measures:

A. Improve MHD-wide Employee Survey scores on "work group access to data about the impact services have on consumers."
B. Improve MHD-wide Employee Survey scores on "use of data on the impact of services to improve services to future consumers."
C. Increase number of "fact sheets" or white papers produced by MHD.

F. IMPROVE WORKFORCE DEVELOPMENT AND DIVERSITY – INTERNAL PROCESS

Goal 6:
Business practices accommodate a changing environment, to include the use of technology to access mental health care and information.

Objective #1:

Use health technology and telehealth to improve access and coordination of mental health care, especially for consumers in remote areas or in underserved populations.

Strategies:

- Survey the mental health community for current uses of health technology and telehealth.
- Continue to support RSN videoconferencing to enhance consumer and stakeholder meeting capabilities, specialty consultations, and remote site access to care and services.
- Explore financial aspects of telehealth use, and coordinating traditional health and telehealth visits.

Objective #2:

Develop and implement integrated electronic health record and personal health information systems**.**

Strategies:

- Survey the mental health community for current use of electronic health records and personal health information systems.
- Continue to support the implementation of the integrated state hospital information system.

- Continue to support the implementation of a person-centered, integrated, comprehensive electronic health record at all state facilities and community mental health agencies.

Objective #3:

Provide employee training.

Strategies:

- One hundred percent of required training will be completed within required time lines. Activities will include:
  1. Assign one staff to monitor, to track, and to report the status of individual employee training.
  2. Ensure that individual training plans are created in connection with the employee evaluation process and with new employee procedures.
- Identify training opportunities on new federal requirements and ensure that at least one staff person attends.
- Identify training opportunities in information systems software and data retrieval methods.
- Offer at least one Quality Management and one best practices training to MHD staff.
- Invite allied systems to quality and best practices training and other educational opportunities.

Objective #4:

Implement an improved risk management program.

Strategies:

- Ensure that the policy and procedures manual is up-to-date and revise as necessary.
- Ensure that department e-mail and Internet policies are communicated to and understood by division staff.
- Define scope of and conduct a risk management review of MHD programs in order to identify risk mitigation activities that should be implemented.
- Implement new federal regulations in a cost-effective manner, including BBA and Health Insurance Portability and Accountability Act (HIPAA).
- Maintain focus on improvements regarding work place safety at the state hospitals.
- Continue to implement compliant billing practices at the state hospitals.
- Improve census tracking, utilization review processes, communication with the division finance office, and planning for a new billing and collections system.
- Offer training to RSNs and providers on consumer rights, and promoting the management of one's own care.
- Address advanced directives for psychiatric care, disenrollment, and fair hearings.

Objective #5:

Improve project management.

Strategies:

- Conduct future planning to identify major projects and initiatives to be completed.
- Develop a standard reporting mechanism to MHD management team for major projects.
- Implement an improved policy on monitoring the progress of major projects.
- Assign project staff to major projects and initiatives
- Develop an All Hazards Disasters Response Plan with all disaster responders covered specific to mental health as their role is defined by DSHS.

Measures:

A. Fund and implement the electronic medical record initiative at state mental health hospitals.
B. Increase number of employees receiving required training.
C. Increase the number of MHD-sponsored training opportunities for MHD staff.
D. Increase number of MHD-sponsored training opportunities for providers.
E. Increase number of MHD-sponsored training opportunities for consumers.

Chapter 5 ● Organization Assessment Summary

PERFORMANCE ASSESSMENT

The MHD has made strides in analyzing performance data and making performance improvement changes. The Joint Legislative Audit and Review Committee (JLARC) completed a Performance Audit of the Mental Health System in 1999, and made 14 recommendations for improved management of the mental health system. These recommendations were in the areas of coordination of services, fiscal accountability, and moving toward an outcomes-based system. Steady progress has been made and reported on an annual basis, with notable gains made in: collaborating with allied systems; improved hospital discharge and community placements; development of a process to quantify and report costs of RSN utilization of state hospitals; development of uniform consumer and consumer service data definitions; and the implementation of a uniform outcome-based performance measurement system. The implementation of BBA regulations in August of 2003 required an External Quality Review validation of compliance, quality and performance. This review of State and RSN performance was completed in early 2005. The in-depth technical report on RSN and MHD BBA compliance was completed in mid-2005. In addition, the Center for Medicaid and Medicare Services conducted an on-site visit of BBA implementation and compliance in April 2005. All of these events have combined to provide MHD with new guidance on managing both performance and accountability.

FINANCIAL HEALTH ASSESSMENT

Community Inpatient Capacity and Cost

Washington hospitals are facing financial hardship and curtailing services in many communities. In February 2000, the state Department of Health reported that hospitals had the lowest net income for any annual period since the state began to collect hospital financial information more than 40 years ago.

Hospital costs continue to rise but reimbursements have not kept pace. New life saving technologies –including pharmaceuticals– improve patient care but cost more, and the additional costs are typically not reimbursed by all insurers.

Hospitals are experiencing a worsening shortage of nurses and other medical personnel. Costs of recruitment and retention are increasing rapidly.

The 2000 Legislative Session provided clear evidence that the combined effects of the initiatives such as the I-601 spending limit, the significant loss of revenue as a result of I-695, and increased demands for education and transportation dollars continue to place the state's health care budget in serious jeopardy of erosion.

Hospital operating margins have plummeted to dangerous, historically low levels. Low margins often force hospitals to curtail services, while inhibiting investment in new medical technologies or renovation of aging buildings and facilities. Hospitals experiencing years of low or negative operating margins face an uncertain future including, in some cases, the threat of closure. This despite the fact that Washington State's community hospitals are among the nation's most efficient and low-cost.

Recent years have been marked by significant changes in the mental health inpatient service delivery system. There has been planning and implementation for greater use of community hospitals for in-patient psychiatric services. For many, there has also been a realization that significant additional funding for mental health services will not be forthcoming.

Hospitals that would once take psychiatric patients through the Medicaid system no longer will, or in some cases, these community hospitals have closed their doors completely.

Loss of State Funds without a Reduction in Requirements

Throughout the past several years, state-only funds have not kept pace with the required responsibility of the mental health system. The system is responsible to provide medically necessary mental health services to persons meeting the statutorily defined public consumer. Conflict arises in funding with the perception in differences in the population defined in statute and the population defined by Medicaid, the other major public system funding source. Medicaid requires services to a much broader group of people.

While some services and persons seeking services are the same, others are not. The system is also responsible for crisis and involuntary treatment services to the general population, to provide the room and board costs associated with community residential care and to provide assistance with employment. These services are not Medicaid reimbursable. Because the MHD pays a capitation rate to RSNs, it is not possible at this time for the division to track the costs of these state-funded services. As such, each budget cut to state funds has further reduced funding available to provide services to non-Medicaid population or to provide the services defined in statute.

Another contributing factor is state fund reductions in other programs that result in reduction of mental health services provided by these allied systems. This includes Children's Administration, Aging and Disability Services Administration, Division of Alcohol and Substance Abuse, Office of the Superintendent of Public Education, Juvenile Rehabilitation Administration and the Department of Corrections. These services are still needed by department consumers, and allied systems believe the RSNs should provide these services. State funding for these services, however, does not follow to RSNs, again requiring them to do more with less.

COST REDUCTION STRATEGIES (See OFM instructions **p. 11)**

- Hospital downsizing/community expansion
- WMIP pilot
- Others

AGENCY SELF ASSESSMENT

The MHD is required by 2005 legislation (E2SHB 1290) to directly procure and assume more oversight of Medicaid managed mental health care provided by the RSNs/PIHPs. At the same time, budget constraints are impacting MHD staffing levels, requiring a reduction of staff by June 2007 (ten percent of current staff at MHD HQ) at a time of expanded staff responsibilities. MHD engaged Mercer Human Resources Consultants to conduct a targeted assessment of MHD's experience and capacity related to mental health managed care. Mercer concluded that a successful implementation of the bill would require MHD to hire additional staff with managed care expertise, restructure to improve its oversight of managed care, and upgrade its information system.

Using Baldridge criteria, the MHD has also performed a performance self-assessment in each of the past four years (2001, 2002, 2003, 2004). Management and supervisory staff of all four sections of MHD are surveyed—Headquarters, Western State and Eastern State Hospitals, and Child Study and Treatment Center (survey return rate was over 30 percent). In 2003 and 2004, the development of a self-assessment quality improvement plan was delegated to the division's Quality Steering Committee (QSC). In 2003, the QSC recommended improvements in the state hospitals' New Employee Orientation (NEO) Program to bring it more in line with national hospital accreditation standards. Mandatory training was a central QSC recommendation; by mid-2005, virtually all MHD employees, both in headquarters and at the state hospitals, have had (or are scheduled for) training in three critical areas: sexual harassment, domestic violence, and cultural diversity. On-line training capabilities also increased considerably during 2004, assisting the QSC in making further improvements in the NEO program. The 2004 self assessment quality improvement recommendations focused on increasing communication across the division, and were developed by the QSC (for the hospitals) and a HQ QI group. Implementation of the recommendations is slated for the second half of 2005 when a new MHD director is appointed.

The Baldridge criteria used by Washington State to assess performance has been replaced by Governor Gregoire with Government Management, Accountability and Performance (GMAP) standards. Based on the Priorities of Government (POG) reviews, it uses a logic model to develop (and focus on) measures that document agency activity accomplishments and progress toward statewide results. GMAP reporting also replaces Performance Agreements and Program/Fiscal Review meetings. GMAP measures developed by MHD will be reviewed and rolled up to both Health and Recovery Services and DSHS reviews.

Chapter 6 ● Capacity Assessment Summary

INFORMATION TECHNOLOGY PLAN (See OFM instructions **p. 10)**

The division will utilize guidelines from the Office of Financial Management for analyzing the information technology (IT) components that support the business needs of the strategic goals and objectives of MHD as an organization. The assessment incorporates the goals (below) of the DSHS IT Plan where they support MHD's business needs.

- Support the DSHS Integration Initiative with business-driven technology solutions that are secure and maintain confidentiality
- Enhance data and analysis capacity to manage budget, caseloads and delivery
- Enhance and maintain information technology across the department to meet changing needs and capacity requirements
- Manage information technology in DSHS using sound project management and quality improvement practices
- Support and enable access to information and services through the use of technology

SUCCESSION OR WORKFORCE DEVELOPMENT PLAN (See OFM instructions **p. 10)**

Goal: Ensure sufficient numbers of qualified candidates compete for leadership positions.

Implement leadership development strategies

1. Implement the Department's Leadership Development Program offering basic, intermediate, and advanced leadership training.
2. Staff will self identify their interest in leadership positions and MHD will provide ongoing leadership development activities.

Identify potential position vacancies in the next five years

1. Identify the type, number, and location in headquarters and at the hospitals of positions eligible for retirement within the next one to five years.
2. Determine by survey or assessment needed KSAs and competencies for current position duties:
3. Review Position Description Forms, Washington Management System Position Descriptions and essential functions of positions eligible for retirement.
4. Notify employees of job classes likely to become vacant within one to five years and the required skills needed for them.

Identify patterns of turnover

1. Identify and understand patterns of turnover by job class for each area.
2. Notify employees of positions likely to become vacant due to area patterns of turnover and the required skills needed for them.

INFORM AND INVOLVE STAFF AND THE UNION IN SUCCESSION PLANNING

As new employees are hired, introduce career and leadership development planning as part of the employee performance evaluation process. Assist interested employees to identify developmental activities that will support growth in knowledge, skills and abilities (KSAs).

Discuss the human resource plan with the Union and keep Labor Management Team informed.

FORECAST FUTURE SUCCESSION PLANNING NEEDS

Identify key changes needed in staff KSAs brought about by changes occurring in business practices, changes required by state legislation and other influences.

Notify employees of anticipated changes and opportunities along with the required KSAs needed for them.

FACILITY PLAN (Optional)

Program Discussion

MHD oversees three psychiatric hospitals that operate as clinical centers for the most complex public mental health consumers as mandated by the Mental Health Reform Act of 1989 (SB 5400). They are the Child Study & Treatment Center (CSTC), Eastern State Hospital (ESH) and Western State Hospital (WSH).

Nearly three quarters of the state hospital patients are admitted pursuant to a civil court order (RCW 71.05). Civil commitment orders are issued by a local superior court from a petition by Designated Mental Health Professionals. One-quarter of the hospital population is committed under criminal process (RCW 10.77).

The 2005-07 Goals of the MHD's Strategic Plan and related MHD Capital Administration strategies include the establishment of the appropriate use and capacity of state psychiatric hospitals, as well as the promotion of services delivered in community settings.

Future Challenges

The Mental Health Division faces several key challenges in the years ahead that will have impacts upon institutional facilities.

1. Reductions in State Hospital and in Community Hospital Bed Capacity.
The reduction in permanent bed capacity mandated by the legislature will continue to add census pressure through the state hospital system. Community psychiatric hospital beds have been in decline, reducing local resources for diverting state hospital commitments. MHD will continue its expansion of community services project and focus on the development of more community residential resources.

2. State hospitals must serve those patients considered too acute or too dangerous for community-based services.
Chapter 205, Laws of 1989 (2SSB 5400), mandate that state hospitals serve the most complicated long-term care patients. Persons receiving care at these facilities show an

increasing acuity due to physical and psychiatric impairments. This requires a higher staff to patient ratio, higher square footage space needs, and increased space for on-site rehabilitation services. Two other statutes are expected to continue to increase the count of hospital patients likely to cause serious harm. Chapter 297, Laws of 1998 (2SSB 6214), encourages the courts to consider hospital commitment for a misdemeanant who has both a mental disorder and a history of inflicting serious harm. As a result of Chapter 214, Laws of 1999 (SSB 5011), a prisoner in discharge process who has a mental disorder, chemical abuse problems, and a history of inflicting serious harm may be assigned to the state mental health system. These challenging populations raise issues of facility configuration and hardening; proscriptions of movement, in addition to internal and external safety features.

3. Preservation and Renovation.
The state hospitals are a key component of the state mental health system. Preserving these assets, renovating them for current use, and re-fitting them for evolving need is a significant part of the program's capital administration.

4. Ensure the effective and efficient provision of ancillary or support services.
Ensure that pharmacy, food service, laundry, commissary, central supply and plant maintenance move from any obsolete buildings and equipment to facilities that allow for efficient, effective and safe operations.

5. Continue to evolve toward a rehabilitation model.
In the spirit of Chapter 205, Laws of 1989 (2SSB 5400), state hospitals continue to evolve toward a rehabilitation model as distinct from a medical model of treatment. New lines of psychotropic medications have enabled large numbers of patients to be discharged from the hospital and to participate more fully in therapeutic activities while in the hospital. The fundamental importance of access to various levels of indoor and outdoor activity - recreational, pre-vocational, and vocational - is becoming increasingly more apparent in the speed of recovery and the permanence of improvement of hospitalized patients.

6. Address Needs of Developmentally Disabled (DD) Patients in Residence.
The WSH lawsuits concerning appropriate housing and treatment of DD persons at WSH resulted in Agreed Orders that mandate some physical separation, staff and rehabilitation efforts, and gender segregation in the forensic wards. Duplicate litigation at ESH is moving through the court system. The appropriate management of this population may require future facility changes.

7. Meet federal/state/county standards in an environment of changing consumers and shifting funding.
As the state hospitals make changes in accordance with statewide program needs, mental health care managers must continue their work to ensure that state hospital practice is in compliance with the expectations and requirements of federal and JCAHO in order to maintain the federal portion of the hospitals' funding support as well as third party insurance. Federal clinical and facility surveys consider over-crowding to seriously deteriorate quality of care and to be a basis for a revenue-impacting deficiency finding. State and county fire codes require particularly close scrutiny and strict monitoring of construction.